STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 100420-001-SF**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 2nd day of December 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 26, 2008, XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on October 3, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received Blue Cross Blue Shield's (BCBSM's) response on October 14, 2008.

The Petitioner is enrolled for health coverage through the XXXXX Schools, a self-funded local government group. BCBSM administers the plan. The issue in this external review can be

decided by a contractual analysis. The contract here is BCBSM's Community Blue Group Benefit Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On June 17, 2008, the Petitioner received a functional upper lid blepharoplasty provided by XXXXX, MD, a nonparticipating and non-PPO-panel surgeon. The surgery was performed in the surgeon's office. BCBSM paid $760.97 of the $9,800.00 charged by the surgeon.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on September 10, 2008, and issued a final adverse determination dated September 18, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's June 17, 2008, surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner believes that if she had been told when she first telephoned BCBSM that she needed a copy of the certificate in order to know her benefits and to explain how BCBSM processed her claim for her eye surgery, she would have understood. She says she never heard of the certificate until her grievance with BCBSM.

According to the Petitioner, BCBSM has given her many different reasons why coverage was limited. The Petitioner says every time she or her surgeon was asked to produce something they complied but then the next denial would cite a totally different reason. The Petitioner says no one at BCBSM has been able to explain why two of her co-workers had the identical surgery and BCBSM covered everything at 80% or more for both of them.

The Petitioner believes that BCBSM has not paid the proper amount for her surgery and is required to pay substantially more for this care.

BCBSM's Argument

BCBSM says that page 4.2 of the certificate clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is defined as the lesser of the provider's charge or BCBSM's maximum payment level for the service. The certificate does not guarantee that charges will be paid in full. Moreover, since the surgeon in this case does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between its charge and BCBSM's payment.

Page 4.4 of the certificate provides that "If the operating physician gives the anesthetics, the service is included in our payment for the surgery". Page 4.24 states the "medical appliances, material or supplies "are not covered benefits when provided by a physician".

BCBSM says further that since the surgeon is also not part of the PPO network and the Petitioner did not receive a written referral from a PPO physician, the approved amount for the surgery was subject to a $250 deductible and a 20% copayment.

The amounts charged by the surgeon and the amounts paid by BCBSM are listed in the following chart:

Procedure	Amount Charged	BCBSM's Approved Amount	Nonparticipating Provider Sanctions	BCBSM Payment
Functional upper lid blepharoplasty (CPT 15823-50)	$4,800.00	$1,201.21	$250.00 deductible + 20% copayment of $190.24	$760.97
Surgical Supplies (CPT A4649)	$3,000.00	-0-		$0.00*
Anesthesia by Surgeon (CPT 00160)	$2,000.00	-0-		$0.00**

* Certificate does not cover when provided by physician
** Anesthesia included in surgeon's payment when provided by the surgeon

The Petitioner says that the only document provided to her by her employer was a summary entitled "Benefits-at-a-Glance." That summary states:

> This is intended as an easy to read summary. It is not a contract. Additional limitation and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan.

BCBSM argues that the Petitioner was on notice that the certificate is the only document that fully explains her benefits.

BCBSM contends that it has paid the proper amount for the Petitioner's surgery and is not required to pay more.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from PPO panel members or from other providers who participate with BCBSM. The surgeon that provided the Petitioner's care on June 17, 2008, is neither a panel nor a participating provider. The certificate warns enrollees (page 4.29):

> If the nonpanel provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial. * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The fact that the Petitioner used a nonparticipating surgeon probably explains why her out-of-pocket cost for the blepharoplasty was substantially higher than her colleagues who had the procedure.

The certificate describes how benefits are paid when services are received from a nonparticipating provider. First, BCBSM only pays its "approved amount" for covered services -- it does not guarantee that the provider's charge will be paid in full. "Approved amount" is defined in the certificate as "the BCBSM maximum payment level or the provider's charge for the covered

service, whichever is lower."

BCBSM's maximum payment level for a blepharoplasty is $1,201.21. If Dr. xxxxx had participated with BCBSM, he would have accepted that amount as payment in full for his services even though his charge was $4,800.00. However, nonparticipating providers are free to request payment for the difference between their charge and BCBSM's approved amount.

Because Dr. XXXXX does not participate, the approved amount for his services is also subject to $250.00 deductible and then a 20% copayment. BCBSM first subtracted the deductible from its approved amount ($1,201.21 - $250.00 = $951.21). Then it applied the 20% copayment of $190.24 ($951.21 x 20% = $190.24) before it made its payment of $760.97 ($951.21 - $190.24 = $760.97). Thus, BCBSM paid 80% of the net approved amount as required in the certificate.

In addition to the physician fee of $4,800.00, the surgeon also charged $3,000.00 for surgical supplies and $2,000.00 for anesthesia. Under the terms of the certificate, a participating provider would not be permitted to charge extra for these services since they are considered to be included in the physician fee (see pages 4.24 and 4.5).

The Petitioner says that she only received a copy of the "Benefits-in-Brief" summary and was not aware of the specific provisions of the certificate regarding how benefits are paid. However, that fact, even if true, cannot be considered by the Commissioner. Under the Patient's Right to Independent Review Act, the Commissioner's role in this case is limited to determining if BCBSM correctly covered the services the Petitioner received according to the terms and conditions of her coverage. The Commissioner finds that it did.

The Commissioner finds that the amount BCBSM paid for the Petitioner's surgery on June17, 2008, is consistent with the provisions of her certificate and that BCBSM is not required to pay any additional amount.

V
ORDER

BCBSM's final adverse determination of September 18, 2008, is upheld. BCBSM is not

required to pay an additional amount for the Petitioner's June 17, 2008, surgery.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.